E. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interest of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

The daily medical assistance payment rate for nursing care for a person in a swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually on July 1 of each year.

SECTION 19.020 **Contracts for services for ventilator dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator dependent person if:

A. Nursing facility care has been recommended for the person by a preadmission screening team.

B. The person has been assessed at case mix classification K (highest rate).

C. The person has been hospitalized for at least six months and no longer requires inpatient acute care hospital services.

D. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator dependent person. The negotiated payment rate must not exceed 200 percent of the highest multiple bedroom rate for a case mix classification K.

SECTION 19.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year

beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 19.030 **Facility serving exclusively the physically handicapped.** Nursing facilities that serve physically handicapped individuals and which have an average length of stay of less than one year are limited to 140% of the other-operating-cost limit for hospital attached nursing facilities. Other facilities serving physically handicapped individuals but whose average length of stay is not less than one year have a limit of 105 percent of the appropriate hospital attached limit.

SECTION 19.033 **Nursing facilities specializing in the treatment of Huntington's Disease.** For the rate year beginning July 1, 1991 and for the rate period from July 1, 1992 to December 31, 1992, the Department will reimburse nursing facilities that specialize in the treatment of Huntington's disease using the case mix per diem limit that applies to nursing facilities licensed under the Department's rules governing residential services for physically handicapped persons to establish rates for up to 35 person with Huntington's disease. For purposes of this section, a nursing facility specializes in the treatment of Huntington's disease if more than 25 percent of its licensed capacity is used for residents with Huntington's disease.

SECTION 19.035 **Hospital-attached nursing facilities.** A hospital-attached nursing facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

A hospital-attached nursing facility is a facility which meets the criteria in items A, B, or C.

A. A nursing facility recognized by the Medicare Program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-attached nursing facilities under the Medicare Program is a hospital-attached nursing facility.

B. A nursing facility which, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, and which has applied for hospital-based nursing facility status under the Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, is considered a hospital-attached nursing facility for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application.

(1) The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare Program's hospital-based nursing facility status been granted to the nursing facility.

(2) If the nursing facility is denied hospital-based nursing facility status under the Medicare Program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

C. The surviving nursing facility of a nonprofit or community operated hospital-attached nursing facility which suspended operation of the hospital is considered, at the option of the facility, a hospital-attached nursing facility for five subsequent rate years. In the fourth year the facility will receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility will receive 30 percent of the difference.

D. For rate years beginning on or after July 1, 1995, a nursing facility is considered a hospital-attached nursing facility for purposes of setting payment rates under this attachment if it meets the above requirements, and: (1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or (2) the nursing facility was recognized by the Medicare Program as hospital attached as of January 1, 1995 and this status has been maintained continuously.

SECTION 19.040 **Receivership.**

A. The Department in consultation with the Department of Health may establish a receivership fee that exceeds a nursing facility payment rate when the Commissioner of Health or the Commissioner of Human Services determines a nursing facility is subject to the receivership provisions. In establishing the receivership fee payment, the Commissioner must reduce the receiver's requested receivership fee by amounts that the Commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the nursing facility. If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee payment shall be set according to

subitems (1) and (2) and payment shall be according to subitems (3) through (5).

(1) The receivership fee per diem is determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the Department has established a payment rate or the estimated resident days in the projected receivership fee period.

(2) The receivership fee per diem shall be added to the nursing facility's payment rate.

(3) Notification of the payment rate increase must meet the requirements for the notice to private paying residents.

(4) The payment rate in item C for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions.

(5) The Department may elect to make a lump sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the Department and the receiver or the managing agent shall agree to a repayment plan.

B. Upon receiving a recommendation from the Commissioner of Health for a review of rates, the Commissioner shall grant an adjustment to the nursing facility's payment rate. The Commissioner shall review the recommendation of the Commissioner of Health, together with the nursing facility's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing facility staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the Commissioner determines that the deficiency cannot be corrected or the need cannot be met, the Commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the Commissioner's review by the nursing facility's actual resident days from the most recent desk-audited cost report.

C. If the Department has established a receivership fee per diem for a nursing facility in receivership under item A or a payment rate adjustment under item B, the Department must deduct these receivership payments according to subitems (1) to (3).

(1) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within

two weeks of the Department's written request, the Department shall compute the resident days by prorating the facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(2) The amount determined in item A must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(3) The per diem amount in item B shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provision of item G apply.

D. The Commissioner of Health may request the Commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The Commissioner, in consultation with the Commissioner of Health, may reestablish the receivership fee payment when the Commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment apply to the reestablishment process.

E. The Commissioner of Health shall recommend to the Commissioner a review of the rates for a nursing home or boarding care home that participates in the Medical Assistance Program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the Commissioner of Health determines that a review of the rate is needed, the Commissioner shall provide the Commissioner of Human Services with: (1) a copy of the order or determination that cites the deficiency or need; and (2) the Commissioner's recommendation for additional staff and additional annual hours by type or employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

F. Downsizing and Closing nursing facilities. If the nursing facility is subject to a downsizing to closure process during the period of receivership, the Commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The Commissioner of Health and the Commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in

the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

G. Sale or transfer of a nursing facility in receivership after closure.

(1) Upon the subsequent sale or transfer of a nursing facility in receivership, the Commissioner must recover any amounts paid through payment rate adjustments under item F which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the Commissioner within 60 days after the Commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(2) If a nursing facility with payment rates subject to item F, subitem (1) is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

Upon the subsequent sale or transfer of the nursing facility, the department may recover amounts paid through payment rate adjustments under this section. The buyer or transferee will repay this amount to the department within 60 days after the department notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

SECTION 19.050 **Medicare upper payment limit rate adjustment.** In the event that the aggregate payment rates determined under this plan exceed the Medicare upper payment limit established at 42 CFR § 447.272, a rate adjustment will be determined as follows:

A. Aggregate the payment rates determined under this plan.

B. Determine the Medicare upper payment limit in accordance with 42 CFR §447.272.

C. Subtract item A from item B.

D. If item C exceeds zero, divide the amount in item C by total statewide nursing facility resident days during the rate year in which item C exceeds zero.

E. Subtract item D from the rate otherwise determined under this plan.

SECTION 19.070 **Downsizing of nursing facilities that are institutions for mental disease.**

A. The provisions of this section apply to a nursing facility that is an institution for mental disease and that has less than 23 licensed beds. A nursing facility that meets these conditions may reduce its total number of licensed beds to 16 licensed beds by July 1, 1992, by notifying the Commissioner of Health of the reduction by April 1, 1992. If the nursing facility elects to reduce its licensed beds to 16, the Commissioner of Health will approve that request effective on the date of request.

B. The Department must be notified by the nursing facility of the reduction in licensed beds by April 4, 1992, and that notice must include a copy of the request for reduction submitted to the Commissioner of Health.

C. For the rate year beginning July 1, 1992, the Department will establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this section by taking into account items 1 and 2.

(1) The Department must reduce the nursing facility's nurse's aide, orderly, and attendant salaries account and the food expense account for the reporting year ending September 30, 1991, by 50 percent of the percentage change in licensed beds.

(2) The Department will adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1991, as in clauses a and b.

(a) Resident days will be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(b) Standardized resident days will be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

D. For the rate year beginning July 1, 1993, the Department will establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this subdivision by taking into account items 1 and 2.

(1) The Department will reduce the nursing facility's account for the nurse's aide, orderly, and attendant salaries, and its account for food expense for the reporting year ending September 30, 1992, by 37.5 percent of the percentage change in licensed beds.

(2) The Department will adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1992, as in clauses a and b.

(a) Resident days will be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(b) Standardized resident days will be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

E. If a nursing facility reduces its total number of licensed beds before June 28, 1991, by notifying the Commissioner of Health by that date, the dates and computations in this subdivision will be accelerated by one year.

F. A nursing facility eligible under this subdivision may use the notification date and the date on which the licensed beds are reduced for purposes of applying the provisions in Section 15.040, item G.

SECTION 19.080 **Disproportionate share nursing facility payment adjustment**. On May 31 of each year, the Department shall pay a disproportionate share nursing facility payment adjustment after noon on that day to a nursing home that, as of January 1 of the previous year, was county-owned and operated, with the county named as licensee by the Commissioner of Health, had over 40 beds and had medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September

30, 1991. These payments are in addition to the total payment rate established under Section 17.000.

SECTION 19.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 14.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 14.010 as soon as possible.

SECTION 20.000 ANCILLARY SERVICES

SECTION 20.010 **Setting payment and monitoring use of therapy services.** At the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services, or to the nursing facility outside of the operating cost per diem. The avoidance of double payments shall be made through audits and adjustments to the nursing facility's annual cost report. The Department will also determine if the materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical

condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, the Department may recover or disallow the payment for the services and may require prior authorization for therapy services or may impose administrative sanctions to limit the provider participation in the medical assistance program.

SECTION 20.020 **Certification that treatment is appropriate.** The therapist who provides or supervises the provision of therapy services must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The Department shall utilize a peer review program to make recommendations regarding the medical necessity of services provided.

SECTION 20.030 **Separate billings for therapy services.** Nursing facilities shall be subject to the following requirements:

A. The invoice must include the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.

B. Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report the revenues received during the reporting year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the Department shall offset the revenues received during the reporting year for therapy services provided to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility's actual resident days. Except as specified in items D and F below, the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the Department to ensure the avoidance of double payments. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the revenues offset shall not be included.

C. For rate years beginning on or after July 1, 1987, nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement to ensure the avoidance of double payments. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of item B, the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the Department's determination of annualized cost and may be subsequently adjusted upon resolution of appeals. After June 30, 1993, property costs excluded from the nursing facility's property related payment rate shall be determined based on